

**AN AUDIT REPORT ON THE
STATUS OF EMERGENCY MEDICAL PLANNERS
IN THE
UNITED STATES AIR FORCE**

**ADVANCED LEADERSHIP ISSUES
IN
EMERGENCY MEDICAL SERVICES**

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ABSTRACT

This research was accomplished to establish a base line towards planning to correct perceived inattention to the recruitment, development, and especially the retention of emergency medical service contingency planners in the United States Air Force (USAF). The purpose of the study was, through a Descriptive Research Methodology, revalidate or invalidate the continued perception that there has been a global inattention paid to the staffing of key emergency medical planner positions world-wide. This perception concluded that such a lack of concern precipitated the continued degradation of planning experience resident at regional and major command headquarters. The result of this degradation translated out in the lack of medical readiness within the USAF which, if not arrested, would lead to an inability of the service to support emergency and casualty generating situations should they occur anywhere in the world. Through a world-wide analysis of emergency medical planner skills, and experiences the research was able to catalogue, and then provide for the analysis of skills for over 150 emergency medical planners from 45 organizations spanning 20 states within the U.S. and eleven nations on five continents.

To accomplish this global survey ten areas of expertise were chosen to evaluate the overall experience of the emergency medical planners. These critical areas were tied directly to the type or level of planning that normally occurs at major headquarters to insure adequate emergency medical/contingency response services are effectively rendered. Interviews were accomplished with each individual capturing the number of years in each of the ten areas.

The major findings of this research confirmed that, while there have been significant progresses in some areas, the overall picture of emergency readiness planner retainability is

continuing to fall, leaving more and more holes in experience and expertise to meet the overall mission expectations. In addition, the research was quantified by headquarters, where good progress had occurred, as well as where unfavorable limiting factors existed. A complete analysis by organization was accomplished and provided to the directing official of that organization.

Although 22 separate recommendations resulted from the study, they basically fell into four major headings including the need, (a) to assign permanent planning positions to key areas of responsibility, (b) increase the number and span of emergency medical planners having Aeromedical Evacuation experience on regional and major command staffs, (c) increase the training opportunities for planners, (d) and finally some how to reverse the negativism and stigma associated with remaining as “one of those planners” versus serving in more traditional peace-time health care delivery administrative roles.

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INTRODUCTION

Since the early 1980s the Air Force and other branches of the U. S. Military Medical establishment have hurriedly tried to recover from the diminished readiness posture left following the Vietnam Era. This included shoring up, in depth, the talented expertise in the form of emergency medical plans and readiness officers, and Noncommissioned Officers (NCO). For without talent planners, the future of emergency medical preparedness within the military would feather away in total disaster. As a result, accession and training programs were instituted in the Air Force to bring on spirited individuals, sharpened through operational experience, to lead the planning for the next decade to help meet the shortfalls being experienced globally in the areas of medical preparedness.

With the end of Desert Storm, the fall of the “Evil Empire”, with the Soviet Union and its surrogates, the complexion of medical readiness while changing, did not diminish as far as scope and necessity. However, the perception for this continuity has at times been lacking in that there has been a significant exodus of senior and experience medical planners to more traditional, and less controversial, health care delivery administrative positions. For years this problem has gone unabated and many discussions ensued on whether a problem existed, and what could be done to fix it.

A decision was made (by the author) to accomplish a worldwide audit of all emergency medical planners and the experience they provided to the service. This audit culminated in an overall research documentation of the situation and quantitative analysis of the problem. It must be noted that this entire project was entirely accomplished on a self-initiated and volunteer basis without direction from higher authorities or as a part of the researchers primary duties.

Therefore the purpose of this research was to:

1. Define the various experience fields required to accomplish emergency medical planning in the Air Force.
2. Fully Document, through personal interviews, the experience levels of all emergency medical planners in the Air Force at all headquarters level positions around the world. Consideration for unit (hospital) level personnel would not be a part of the analysis.
3. Catalogue the cumulative experience levels available at the 45 separate organizations. (See Appendix A).
4. Provide an analysis into the levels of experience displayed through the surveys
5. Identify shortfalls in experience at all levels in the study
6. Project future shortfalls based upon identified trends and forecasted events
7. Make recommendations to the Surgeon General of the Air Force to fix current problems associated with the conclusions and prevent reoccurrence in shortcomings in the future.

To accomplish the analysis, a series of ten experience identifiers were defined and interviews were held with each of the 150 or so individuals queried in the study (See Appendix B). This form of Descriptive Analysis Methodology was chosen because of the large number of individuals and large spanse of geodgraphy that it would cover. Over 35% of the interviews were done face to face, the remaining were done either through video teleconferencing, in groups of three to five, or individually by telephone. Of the 158 individuals selected in the study, only one could not be reached and information had to be gathered from previous supervisors or co-workers.

BACKGROUND AND SIGNIFICANCE

As previously stated, with the change in the world order came a diminished focus by many into the areas of readiness, especially seen in the area of emergency medical readiness and preparedness. This was to a certain point understandable considering the effort and intensity to meet the Soviet Union head on to prevent World War. However, as history has shown, breaking up the polarizing power projection leaders did nothing more than let the small town bullies and evil quagmires out on the street in an unabated fashion. As a result, the concern for emergency medical planning has expanded its measures beyond that of direct support to military forces engaged against each other. It has spiraled into an overlapping series of new frontiers of planning taking into the consideration worldwide foreign and now domestic terrorism; and Missions Other Than War (MOOTW), to include peacemaking, peacekeeping, and humanitarian relief operations. With all of these came a new surge in requirements for trained and experience emergency medical planners that were capable of recognizing threats, providing timely estimates and analysis, and finally defining the resource requirements necessary to support those future operations.

Unfortunately the number and depth of experience of these required planners has diminished over time. This has been a result of poor attention, lack of recruitment, sustainment (by promotion or recognition), overwork, and increasing separation and travel away from their families. But more importantly there was a growing dissatisfaction throughout the ranks of planners that lip service was being paid by the senior leaders in the areas of readiness in the face of such day to day issues like managed care. The result of this exodus has been the degradation in planning and response capabilities by the services, fortunately not challenged yet by a new crisis capable of saturating the already degraded capability. For example the number medical

planners in the Air Force had dropped from 108 in 1990 to just 78 in 1995. Fortunately in 1998 that number had gone up to around 90. But that was still short of the 96 which were available in 1985 when the surge in readiness was just beginning. (See Fig 1)

The concerns expressed in this study are not to distant from those seen in the various issues identified in the National Fire Academy's Advance Leadership Issues in Emergency Medical Services. While the study may be more international in scope and characteristically more framed in the contingency or combat nature of emergency medicine, none the less the study identifies (and then recommends) fixes to a situation which if left unchecked will strangle our ability to provide casualty care in the future. It forms a basis for the same marketing strategies taught in the course. The research provides the foundation for both primary data and secondary research necessary to identify a problem and establish goals with objectives to mend the seams of concern. Through the research, eight issues are identified and 22 recommendations made.

These issues and recommendations were briefed to the Air Force as a corporate institution on three occasions. First to the Surgeon General's Medical Readiness Director and Staff in Washington D.C.(See Appendix D), second to the body of senior medical planners in a 14 location (three continent) Video Teleconference, and then finally to the community of medical planners at the annual medical readiness symposium held in San Antonio, Texas. A final capstone to the overall research has been the direction taken by the Air Force Surgeon General in making the recommended baseline corrections to the Medical Readiness Strategic Plan. As a result, a strategic planning procedure/process for monitoring the fixes was instituted and is being reported up the chain of command every month (See Appendix F). This final step makes up the recommended process flow as provided in the Issues Chapter of the aforementioned course. Without this heavy hitter, General Officer focused follow-up; the

research would offer nothing more than a bag of data and good ideas.

LITERATURE REVIEW

This research is the first of its kind in the history of the Air Force and no precedence for such a study is documented anywhere. It was accomplished through an exhaustive research process accomplished at numerous Air Force and Joint headquarters as well as many military universities. Research for such materials was accomplished at the National Emergency Training Center's Learning Center; the Air Force History Office and Headquarters USAF, Bolling AFB, D.C.; the Army War College, Carlisle Barracks, Pennsylvania; the National War College in Washington D.C.; the Armed Forces Staff College in Norfolk, Virginia; the Air University at Maxwell AFB, Montgomery, Alabama; Headquarters Air Combat Command, Langley AFB, Hampton, Virginia; Headquarters Air Mobility Command, Scott AFB, Illinois; as well as both the School of Aerospace Medicine, Brooks AFB, and Headquarters Air Education and Training Command, Randolph AFB, San Antonio, Texas. Fortunately the researcher's primary military duties offered opportunities for travel to these centers for military study.

However, this study is not absent literature for foundation. Primarily in the form of declassified studies the researcher was able to gather rare reports for documenting the historical precedence of U.S. military concerns for the necessity of having emergency medical planners.

The first document that I draw your attention to is a declassified copy of what historically was known always as the *Zimble Report*. The *Zimble Report*, 18 April 1984, was a study developed by a the Department of Defense formed Medical Readiness Review Group, and led by Rear Admiral James A Zimble. The group and study were commissioned by Congress to

investigate the medical response and planning in the face of the (then recent - 23 October 1983) Beirut, Lebanon barracks bombing. The overall conclusion of the report indicated that none of those who had died of wounds received less than desirable care. However, it also concluded that had the number of dead to wounded been reversed (increasing the number of survivable injured to over 200) then the system would have been over stretched to care for them (Zimble, 1984). The overall conclusion pointed directly to a failure to plan, and more specifically have dedicated planners to support casualty care in support of these missions. The bottom line was that if the U.S. could not spontaneously support a generated casualty load of 200, then how could we plan to execute the care for thousands (a day) in a war against the USSR. The most powerful recommendations from this group to Congress were the robusting of trained and experienced planners who would form the foundation for future emergency contingency planning (Zimble, 1984). Simultaneous to this report's conclusions were those ratifying remarks which followed from the Urgent Fury, Grenada Invasion reports (Meyer, 1984). If you remember, both operations occurred simultaneously as far as casualty care goes.

The *Zimble Report*, while focused primarily on our lack of planner capabilities in Europe, spawned another study known as the *Jordan Report*. Congress took the information from the former *Zimble Report* and levied a Department of Defense Review of the Pacific area. This became known as the Senator Kennedy driven *Jordan Report* named after Brigadier France F. Jodan, then the Deputy Assistant Secretary of Defense for Health Affairs. His report, dated 1 June 1984, identified numerous shortfalls in the Pacific area of operations to include poor logistics, and once again planning (or the lack there of). The *Jordan Report* became even more of a heavy hitter and foot stomper for the need of medical planning and planners (Jordan, 1984). Section II of the report provided three pages of in-depth recommendations for increasing the

number of planner positions and staffing for these positions throughout Korea, Alaska, Japan, the Philippines and Hawaii. Finally facts were being provided and people were starting to take note of the requirements (Jordan, 1984).

Bringing it closer to home in the Air Force the Medical Readiness Assessment Group was formed by the Surgeon General of the Air Force in 1994 to study issues and concerns associated with the readiness of the service. It also ratified the concerns of the *Jordan* and *Zimble Reports* in its November 1984 final report (HQ USAF/SG, 1984)

And finally, after three years of deliberation the Department of Defense published (in February 1988) its long awaited Medical Readiness Strategic Plan. It was the intent of this plan, which is now in its third generation; to mend the concerns and shortfalls originated in the reports following the Beirut disaster. It had been spawned through the hard work of dozens of planners from all services. Its origins came from the 20 June 1986 direction from the Secretary of Defense for a Medical Program Review Committee (MPRC) to assist the Assistant Secretary of Defense for Health Affairs regarding medical support resources and planning. From that group came the *Medical Readiness Objectives - 1992 Program* designed to meet the emergency medical planning and resource requirements for the next decade (Mayer, 1988). They, in 1986-88 would never realize that aware with an unplanned enemy (and not the USSR) would occur in 1990-91 and that medical readiness would begin to degrade by 1992.

One of the most interesting points about the literature review is that other than those documents which preceded the 1990s, very little has been written relative to the need for trained and experienced planners, and to this end we can point to the dilemma. There are volumes of documents, which discuss the need for planning. Planning for rapid response; for efficient aeromedical evacuation; for blood programs; for dedicated communications and information

systems; for host nation support; and (not finally or inclusively) planning for the employment of prepositioned stocks and use of the reserves. However, no one ever talked about planning for planners. Where were all the planners going to come from to do all of this required planning?

PROCEDURES

Definition of Terms

At this point it is probably important to establish some common terminology to insure that the reader can fully comprehend the language and command relationships in the area of Emergency Medical Planning within the military and especially the Air Force. For the purposes of this study, the term medical readiness officer is considered synonymous with emergency medical planner. Likewise reference to medical readiness is identical to emergency medical planning. As far as command relationships go the Air Force has numerous layers of command, responsible for a full spectrum of specific functions or levels of planning.

At the peak of the planning process are the Offices of the Assistant Secretary of Defense for Health Affairs and the Office of the Joint Chiefs of Staff. These offices share a common purpose but have separate authorities and responsibilities. The Office of the Secretary is responsible for policy and programming actions for the obtaining and divestment of funds from the congressional budget to the services as well as managing the Department of Defense's Medical Readiness Strategic Plan (affectionately known as the MRS-P). The office of the Joint Chiefs is responsible for establishing planning direction for the services. They initiate the planning process and are key to providing interface between the President and the Joint Commands during crisis.

Supporting the global execution of emergency medical service planning are the planning

staffs of the Unified Command Surgeons. These staffs provide planners from all the services and are responsible for the overall planning for separate regions in the world or functional expertise (like Transportation Command and Special Operations Command). There are nine of these commands, but there were Air Force representatives on only five of them (this was a problem identified in the study). These headquarters may or may not have Sub-Area plans offices. There are ten of these Sub-Area planning staffs located in Saudi Arabia, Korea, Turkey, Belgium, Italy, and five within the U.S. for regional disaster planning and liaison with the Regional Federal Emergency Management Agency (FEMA) offices. All but one of these staffs has Air Force representation (Korea - another problem). A form of these type of planning offices is the Joint Task Force (JTF) Surgeon's staff. A JTF is a temporary command charged with the responsibility for a specific bubble within a region to execute a specific mission. An example would be the JTF-Southwest Asia (SWA) charged with the responsibility of enforcing the no fly zone over Iraq. There is one medical planner assigned on a 120-day rotational basis in Riyadh, Saudi Arabia to support this mission. Since Desert Storm there have been over a dozen come and go JTFs established to support missions in SWA, Bosnia, Rwanda, Haiti, and many other locations. Each would have a surgeon staff with a medical planner assigned. Supporting these temporary headquarters would be component headquarters from the four services. The USAF service component headquarters is called the Air Force Forces or AFFOR Headquarters with a Surgeon Director and a staff of planners. An example of this was the AFFOR Headquarters called U.S. Central Air Forces (USCENTAF) under General Chuck Horner, running the Air Campaign during Operation Desert Storm. The Unified Command was U.S. Central Command under then General Schwarzkopf.

(It is important to note at this point that all the headquarters mentioned in this description*

were all included in the analysis)

Supporting them are Air Component planners located at the regional Air Force Headquarters. These planners are responsible for supporting the joint commands above them and manage the emergency medical and hospitalization resources assigned to the Air Force in region. There are three of these Regional Major Air Commands (MAJCOM) in the Air Force, one in Europe, one for the Middle East, and one in the Pacific.

Below the Regional MAJCOMs there are Numbered Air Force (NAF) planners assigned to exclusively concentrate on regional contingency planning and response. They may report to an MAJCOM Headquarters, or in the case of Korea, the Middle East, and Latin America (Central, South America, and the Caribbean) report directly to a joint headquarters. There are six of these NAFs with medical planners assigned, one in Korea, two in Europe, and three in the U.S. focused on Middle East and Latin America operations.

Another chain of headquarters are those charged with organizing, training, equipping and (if necessary) mobilizing emergency medical resources for crisis. These are headed by the planners located in the Office of the Surgeon General, Headquarters USAF (Air Staff) in Washington D.C.. Not surprisingly this office has the largest number of planners and widest spectrum of experience (but not necessarily the most experience). They guide a number of MAJCOM Surgeon planner offices located in the continental United States. There are six of these staffs supporting their headquarters and command for emergency medical planning.

One type of staff, which serves at a much higher plain, but was not mentioned, (because it does not fall under U.S. command) is the Combined Headquarters Staff. Combined Headquarters are those serving under multiple foreign flags. Headquarters like the North Atlantic Treaty Organization, Headquarters Supreme Allied Forces Europe, the United Nations

in Somalia (or where ever), and Combined Forces Command (Korea) are examples of these type of headquarters where international coalition medical planning is accomplished. At present Air Force officers serve on three of these type of staffs.

There are numerous other specialty staffs all performing planning activities throughout the U.S. and all of these are included in the study.

In addition, other terms of reference will come out in the study, especially when we discuss the categories of measurement and areas of specialization.

Research Methodology

The desired outcome of the study was to document, in an objective and quantitative method, the status of medical planner experience and the level of that expertise in various planning offices around the world, identify concerns and issues, and make recommendations for corrective action. The objectives contributing to this study were to:

1. Identify all of medical planning functions and individuals contributing to emergency medical planning in the Air Force at the higher than individual unit level. This would include planners currently in headquarters positions and those still on active duty, but serving elsewhere.
2. Identify the centers of gravity in medical planning that would be evaluated as in a metric by years of experience.
3. Capture and meld the years of experience with the planners in determining the overall levels of experience available on each of the plans staffs.
4. Identify strengths and weaknesses in plans staff capabilities.
5. Make recommendations for changes/fixes.

The methodology chosen to extract this information and accomplish this research study was the Descriptive Research Methodology. The sampling, technique selection, and collection

activities were accomplished to gather the most and complete information in order to make conclusive and objective findings. These findings led towards definitive recommendations which drove strategic action planning by the Surgeon General of the Air Force.

Because the research had to be conclusive in its findings, a 100% sampling would have to be accomplished. In other words every medical planner or anyone with headquarters level planner experience would have to be canvassed in the Air Force. This required multiple interviews with individuals, supervisors, and command surgeons from today and the past to fully build a family tree of planner from all the 45 individual staffs. It also meant working with the Air Force Personnel Center (AFPC) at Randolph AFB, San Antonio, Texas to help locate individuals (including retirees). While the study gathered information on only active service individuals (including active reservists, guardsman, and civilians), to accomplish the study, over 20 retired and separated officers and NCOs were contacted to help find out who had been where, and when. As a result of the three major presentations made, there have been no questions raised as to the 100% capturing of the total population of medical planners in the Air Force.

Finding the individuals would only be half of the process for gathering the information. Gathering critical experience indicators would be the other half. But before that happened the critical indicators of experience would have to be defined. This was done by searching the major processes that the Air Force Medical Readiness Strategic Plan focused on as well as where medical planning was accomplished. Ten areas were selected and discussed with a body of senior planners who helped keep the research sane throughout its journey.

The ten areas included.

1. Years of experience in a Joint Unified Command Headquarters.
2. Years of experience in a Combined International Coalition Headquarters.
3. Years of experience in a MAJCOM or NAF Headquarters
4. Years of theater plans experience. This area was not fully described in the definition chapter, but is one that requires some addressing. This type of experience can be acquired at the Unified/Combined level, overseas MAJCOM, or at a NAF.
5. Years of experience at the Air Base or Unit Level
6. Years of deployed real-world contingency experience. While this is not necessarily an assignment, it brings an operational perspective to any plans office. If you have been there in the heat of it all, then you will be a better planner.
7. Years of experience in a non headquarters special staff activity function involved in the management of emergency medical planning activities.
8. Years of experience assigned to an Aeromedical Evacuation Squadron (AES). Because Aeromedical Evacuation (AE) is what we call a Core Competency within the Air Force, a good foundation of knowledge and especially experience is necessary in this area for the planner to be effective.
9. Years of experience assigned to a Special Operations planning function or unit. Special Operations (like AE) comes with special skills and knowledge that cannot be replicated through reading alone. Experience is key and was captured in the research to provide the best overall picture of planning strengths.
10. Years of experience assigned in readiness at Headquarters Air Force, Office of the Surgeon General.

Action Plan Elements and Execution

The data gathering portion of the research was conducted by interview. There were four basic methods for this interviewing process. In all cases the interviews were scheduled to meet the constraining schedules of those interviewed.

The first type of interview was the simple face-to-face, one-on-one discussion with the participants. Because of the close interaction that medical planners have on a day by day basis, most of those interviewed were prepared to discuss their backgrounds, and understood the reason behind the research and the hope for good it might drive. The challenge with all the interviews was the validation. Some interviewed attempted to claim experience (especially in theater planning and AE) that could not be validated. This was either because they did not fully understand the definition or because they felt that their other experiences included it. No real problems ensued during these discussions and approximately 10% of the interviews were accomplished in this fashion.

The next largest were those interviews done in groups of two, three and one five. These were done either by teleconference phone interviews or by face to face Video Teleconferencing (VTC). Three interviews were done with overseas units by VTC. About 35% were interviewed in this fashion.

The next was through simple one on one telephone interviewing. This captured the largest of the sampling (50%) and provided the simplest method.

The final method of interviewing was by questioning past supervisors or peers. This was only done on that small percentage of individuals who had just retired, and could not be contacted, or those who were unavailable for contributing. At this point I need to state that no one refused to participate. But for those who could not be contacted, normally two or three

others were contacted who had worked with the individual and could validate his/her experience. Never was only one person's validation taken as the final say.

Limitations

Part of the sampling process was to target a specific window of time to freeze the analysis at. This was because of the constantly changing environment in the military especially because of the mobility of individuals in changing assignments. As a result, the target date of the "Snapshot" was effective 1 October 1997. In other words, the analysis would be based upon those individuals assigned to positions on that date. Since that time there have been some changes which will help fix the findings.

The only other limitations on the scope of the sampling and interview process were those who fit the criteria for experience. There was no discrimination to active or reserve personnel or primary career field, or between officer and enlisted. The purpose was to capture the entire spectrum of individuals currently or having previously served as planners. As a result, a 100% sampling was accomplished. Limitations were not a factor in accessibility to individuals as numerous methods of media were available to accomplish the sampling. Classification of missions did not impact the study either.

RESULTS

The results of the research can be broken down into those that were targeted for results and those, which came as a surprise, and were not projected to be discovered in the study sampling.

Targeted Considerations

1. There has Been a Significant Exodus of Experience Medical Planners From the Air Force.

Since 1995 the study found that over 1,008 years of experience was lost to individuals retiring, separating from the Air Force or changing jobs out of the Medical Readiness field. In over three years this exodus increased from 263 years in 1995, to 347 years in 1996, to finally 398 years in 1997. In 1997 this included 52 individuals.

2. Most Plans Positions Are Being Filled. In spite of the exodus, most planning positions continued to be filled, however not always with experienced or qualified individuals. Some positions were unfilled for the entire year of 1997. Others were continued to be filled with good officers and NCOs with no historical background in medical readiness. This was because it was felt that “potential” outweighed “experience.” This is an important point, and it left the leadership of the Air Force with false expectations, and increased the burdens on the already heavily tasked tenured planners to train apprentice senior leadership (as well as new planners) in the technical aspects of the art. It also increased the staffing time on many projects because of the necessary “spin-up time” of the bosses to level the playing field so they could articulate the programs effectively enough to get resources programmed. “Lessons Learned” over time never became “Lessons Remembered,” because the senior leadership in medical readiness had not been there, like their predecessors, “when the page was blank.” An example was in 1996/7 when over eight of the officers filling senior leadership positions in medical readiness had less than a year of experience in the subject. And none had served in a MAJCOM readiness planner position in their past.

3. Some Unified and Sub Unified Commands Remained Unsupported With Experienced Planners. Positions at these type of commands usually requires individuals who come with

significant Air Force Medical Readiness experience. Because of the exodus the number of these individuals has diminished. Over time some previous positions have gone away. At this time the planner positions at U.S. Pacific Command are filled with individuals with less than two years in the business (mostly from their current assignment). There are no Air Force medical planners serving on the Sub Unified Command U. S. Forces Korea Surgeon staff. There were a colonel, a major, and a senior NCO positions at one time in that region to assist in that critical contingency planning. But these went away over time and were never filled. There were Army and Navy planners on this staff, but no Air Force representative. There was only one inexperienced NCO serving on the U.S. Southern Command Surgeon's staff supporting Latin America operations. At one time there were two officers and one NCO position assigned to this staff. (Note: as a result of this author's work with that command (supported by this study), and support from the Air Force Surgeon General, a Lieutenant Colonel planner position has been put on the books and advertised for fill to support this staff). There were no medical planners assigned to the U.S. Central Command Surgeon staff supporting Middle East planning. At one time there were three Air Force plans officers assigned to that staff.

4. *Good Experience in Base Level Plans Was Found At All Levels.* Other than the situation found at Headquarters Pacific Air Forces (PACAF), all of the commands hosted a staff that was very versed in base/unit level emergency medical service planning issues. This was important because of the hundreds of medical units and bases that these commands were responsible for in the areas of medical readiness, disaster planning and response. Unfortunately PACAF had no one on its plans staff that had any experience at the unit level. One senior officer on that staff was quoted as saying "and it shows throughout the Command."

5. *Staffing Of JCS, OASD-HA and USACOM Were Good Benchmarks.* The small staffs at the

highest levels of planning in the Department of Defense had good representation in the full spectrum of skills and experiences necessary to accomplish the mission at their level.

6. *Unified Commands and Joint Commands Were Absent Aeromedical Evacuation Planning and Operations Experience.* With the exception of European Command, all of the other Joint Commands were absent AE experienced individuals. This is a serious problem since the Air Force is responsible for that essential medical mission.

7. *Theater Plans Staffs Were Lacking in Theater Planning Experience.* All of the overseas and NAF planning staffs lacked significant experience in theater planning. This was their main mission, and many were having to learn these skills while on the job as opposed to arriving with the experience to accomplish their roles in medical planning.

8. *Major Shortfalls Existed in Planners and Experience Dedicated to SWA and Korea.* These two areas of operation are characteristically our nations greatest regional threats for future conflict. Much of our regional conflict planning efforts are focused in theses directions. Unfortunately we had the least amount of experienced individuals assigned to the headquarters responsible for their planning. Korea had one officer who had recently graduated from a one-year fellowship, but had no other experience. CENTAF, managing Middle East operations had one NCO with significant experience and one officer with barely the minimal experience enough to know when it was time to listen to the NCO.

9. *Theater Aeromedical Evacuation Experience Was Lacking on All Theater Planning Staffs.* Aeromedical Evacuation planning involves the melding of theater Command & Control, patient movement processes, patient casualty staging, and the management and employment of crews. This is what is known as Theater Aeromedical Evacuation System (TAES) planning. While this is a significant part of any theater planning process, very few individuals have experience

accomplishing that art. At the time of the “snap-shot” only two commands had a planner assigned who understood these essential principles.

Unexpected Discoveries

1. *One Command Was Planning On Mal-assigning Individuals From The Fellowship Training Program.* The objective of the medical planner fellowship programs is to train individuals in the art of headquarters and theater planning. It is not intended to teach individuals staff processes only to return them to base/unit level duties. This was a malpractice in the past, which, after once corrected, has raised its head again in one MAJCOM. Once briefed of this circumstance the Surgeon General’s Director of Medical Readiness directed that the practice be halted.
2. *There Were No Base Level Planners Available OnThe Governing Headquarters Staff of One MAJCOM.* This concern was discussed in the previous paragraph on base level planning.
3. *Good Marks For Experience Were Displayed By Planners In Special Operations Headquarters Staffs.* Individuals assigned to the Special Operations Unified Command, MAJCOM, and Regional Squadrons had significant unit/base level, theater; as well aeromedical evacuation planning and operations experience. In addition, all of the staff planners had served in a theater, MAJCOM plans staff function, and had overseas contingency real-world operations experience. This contributed to a well-balanced and mature planning function.
4. *Headquarters Air Force, Office of the Surgeon General Department of Medical Readiness, Displayed a Wide Spectrum of Experience.* For the first time in many years the Office of the Surgeon General retained a staff will a full spectrum of experiences in most areas of medical readiness. JCS, Unified Command, MAJCOM, Theater NAF, Aeromedical Evacuation, and base level experienced individuals were resident on the staff.

5. *There Were No Medical Planners Assigned To Headquarters U.S. Transportation Command Who Had Any Aeromedical Evacuation Experience.* As the lead command for worldwide aeromedical evacuation, it is startling to begin to believe that this had occurred. Fortunately the close association and proximity with its Air Component Headquarters reduced the impact placed on the other supported commands. However, this is a situation that should be corrected.
6. *Officers Assigned to Key Medical Positions On Air Force Battle Labs Had No Plans or Operations Experience.* A number of Air Force Battle Labs were established in the last couple of years to concentrate on specific issues relative to Air Force Operations. Two of these staffs had medical personnel authorized. One had personnel assigned, but none had assigned individuals with contingency plans and operations/readiness experience.
7. *There Were No Medical Planners With Aeromedical Evacuation Experience Assigned To The Air Force School Of Health Care Sciences.* The school responsible for providing the initial training for medical planners had no one on the staff with experience in aeromedical evacuation operations and plans.
8. *The Officer Assigned To Support The Air Force Doctrine Center Did Not Have Readiness Experience.* The Air Force Doctrine Center had authorized one person to be assigned to their staff. The decision was made to allow this person to reside on the Air Staff, but had no readiness experience.
9. *Catastrophic Staff Experience Collapses Were Predicted For Two MAJCOMs Unless Fixes Were Employed Soon.* It is expected that significant losses of experience will be realized during the summer of 1998 at Headquarters Air Mobility Command as a result of reassignments and retirements. In addition, Headquarters Air Combat Command will lose some of its tenured expertise in 1998, but is facing a major turnover in 1999. Both of these situations are recognized

and documented, and action is required to prevent staggering implications if the effects of both are not prevented.

DISCUSSION

In 1979 the Air Force Surgeon General began a concerted effort to revitalize the readiness capability of the medical service, since lost or significantly diminished in scope and capability since the Vietnam era. To accomplish this monumental task a new family of emergency medical plans expertise would have to be grown and developed. Training was only one part of the equation. Recruitment and retention would also be necessary.

From 1979 through 1990 there were three basic tracks available, or made available for recruitment, acquisition, and initial training of future medical planners.

1. The first would be the cheapest, but most stringent on the medical service, with less initial payoff. This considered direct accession from the health care management career field of Medical Service Corps officers traditionally bred in the specialties of patient administration, financial/resource management, medical supply, and general administration. Some of these early on accessions came with some limited local disaster response planning experience. Some, but very few, came with experience in AE operations. This latter field of experience, while recognized as an essential element of the AFMS mission, was only considered a “career broadener” and not one which an individual should become entrenched in or in other words become a specialist. (Note: To do so was considered suicidal towards a career, and subsequently verboten.) These individuals had a long and very steep learning curve and fell to the whims and drifts of the professional planners and non medical programmers in the Air Force. The one thing that these officers came with, which carried them through those early tough years, was a heart and drive to make a difference. A difference that would be paid off someday in lives saved on

the battlefield, on the air bases, and during the enroute phases of the AE missions. By 1988, at the peak of our readiness growth, about 25% of the planners at Air Force Headquarters had come up from this arduous process of growth, and constituted the maturity, continuity strength, and trainers for planning community.

2. The second group of accessions were those officers who had just completed in-resident attendance at an Intermediate and Senior Service School where the art of contingency planning and programming was taught. These schools primarily included the Air War College (AWC) and Air Command and Staff College (ACSC) in Alabama, and the Armed Forces Staff College (AFSC) in Norfolk, Virginia. Most came out of the later AFSC joint program. This was because it was a more convenient course, with more concentration on planning art, and was only six months long versus AWC and ACSC, (which were a year long assignment). In the later years other schools would become available, like the National War College and Industrial College of the Armed Forces, both located in Washington D.C.. These later schools would never be depended upon for initial accession training, but for refinement and professional military development. Approximately 35% of the planners came from formal schools. Unfortunately the AFSC has been reduced in scope and is not available for initial accession training. It was by far the best formal institutional program for initial development of planners.

3. The third, and I think the most successful accession route, was through fellowship/internship resident programs. These programs provided a less stressful learning environment for future planners. During the training period (normally six months to a year) an officer would serve under a mentor learning the basic skills of headquarters staff work, contingency/emergency planning art, and the technical aspects of the full spectrum of medical readiness programs. He/she would attend formal schools teaching these subjects; and participate in day to day

headquarters projects, exercises, and real-world operations. These formal courses included two courses down at the Air University; and others at the Joint Readiness Training Center, San Antonio; the School of Health Care Sciences at Sheppard AFB, Wichita Falls, Texas; Airlift Operations School, Scott AFB, Illinois; Special Operations School, Hurlburt Field, Ft Walton Beach, Florida; and finally short courses provided through the Armed Forces Staff College, Norfolk, Virginia. In 1989 a dedicated course for medical planners was established at Bethesda, Maryland. This course had been under development for three years. It became known as the three week Joint Medical Planner's Course. The fellows would also travel around the world observing theater planning, exercises, and the operations of various elements in the medical readiness system. Because they were in a student status they were not placed in the same position as direct accessions, who had the burden of arriving, without a fellowship honeymoon, and hit the ground running (regardless of what they did or did not know). Initially there were two types of fellowship programs.

a. The six-month program where an officer would serve in a training mode under a medical plans mentor at a large USAF medical center. He/she would be afforded the opportunity for attending planner/programmer-focused training at the Air University and other institutions. But their primary focus would still be at the facility level (although on a much larger scale), and not on theater, or macro planning levels. This type of program lasted until 1985 when it was eliminated in favor of expanding the next program.

b. The second and most successful of the fellowship programs was the one year fellowships hosted at Headquarters Air Force, and at large MAJCOM Headquarters. The initial program (1980) offered three positions per year. One in Washington, one at Langley AFB at Headquarters Tactical Air Command, and the last at Ramstein AB, Germany. In 1983 the Air

Staff position was transferred to Headquarters Military Airlift Command at Scott AFB, Illinois. In 1984 a fourth fellow (nurse) was started at the Medical Wartime Hospital Integration Office, Ft Detrick, Maryland. In 1989 the first fellowship program was started in the Pacific for Headquarters Pacific Air Forces at Hickam AFB, Hawaii. In 1995 the first nurse medical planner fellowship program was started at Headquarters Air Combat Command, Langley AFB, Virginia. And by 1996 the Langley program was hosting three fellows, including two nurses and one Medical Service Corps officer. This was the peak in fellowship years with six medical planners being turned out in the summer of 1997. In the late summer of 1997 an AE planner fellowship was opened at Scott AFB. Finally in 1997 a medical planner fellowship was initiated on the JCS Medical plans staff.

Today there are five planner fellowship programs available. Critical, but not enough to meet the demands, continuity of the planning, decline of medical planners, and increase in planning requirements. To meet the requirements, there needs to be six commands offering fellowships, turning out no less than eight fellowship graduates a year.

The coupling of these three accession programs allowed for an early slow start, but a steadily increased tempo of growth in medical planner positions and experience around the world. Unfortunately the Winds of War and Winds of Direct Health Care Delivery, would tear many of these tenured individuals away for use in the 1990s.

The Gulf War found the AFMS in an excellent position as far as readiness expertise. The drain of planners had not begun and the service enjoyed a high profile in its ability to plan and execute the ensuing war. Unfortunately after this adventure, along with the collapse of the Soviet Union, and its surrogates, the need for planners diminished in the minds of those few that had made a career in the art. Facing the pain of another “between wars transition period,” many

felt that they had paid their dues and were not up for the next mountain to climb.

The peacetime dividend following the tearing down of the Berlin Wall was more of a major cash withdrawal, with little investment elsewhere in readiness. Since those sequence of events many of the tenured strength went into direct health care in hopes of better promotion opportunities, or in preparation for retirement (and the need to show, on their resumes, that they had done more in health care management than cold war medical readiness planning). This was an unfortunate, but understandable human gravitation. They were looking out for their careers, and their family's future. However, the AFMS was left with a dwindling foundation of medical readiness expertise. Most of those who escaped were from the formal school and direct accession programs. However many fellowship graduates also moved on. At this time there are about 20 of the 40 plus fellows trained by the Air Force occupying planner positions around the world. This was a 50% retainability in the investment. Another five or more are still available in the Air Force in hospitals if available in later assignments.

Another major metric to review the status of medical planner expertise was the number of full Colonel tenured medical planners in the Air Force. In 1985 there were 12. In 1990 there were 14. In 1997 there were three with plans experience and serving in planning positions. Five other Colonels were serving in key readiness positions, but none had served as planners, and only one had up to two years of experience in readiness (primarily in their current positions).

The future of Air Force Medical Readiness falls into three areas.

1. The first is in the leaderships hands and its dedication and commitment to medical readiness. There are over 500 planning documents in circulation that the AFMS is responsible for development or coordination. There were also over four dozen issues in the DoD Medical Strategic Plan that required significant planner work to make come to fruition.

2. The second is budgetary. Without a strong investment mechanism to pay for (and field) upgrades to our field treatment assemblages, information/communications systems, aeromedical evacuation elements/systems, blood management and logistics programs, and propositioned stocks and research, we will continue to have dwindling (and out of date) programs, equipment/supplies, and training.
3. The third is the need to continue to reinstitute a strong readiness planner program. Without the later, the second will not occur. Without the later the leadership of the AFMS would have played its cards face up and let their real focus be known. Medical Readiness, trumped by peacetime health care delivery concerns.

It is hoped that this research was capable enlightening the minds of the Air Force senior leadership into initiating change and focus towards shoring up this vital piece of our readiness capability. Through the Surgeon General's Medical Readiness Strategic Plan hopefully the demise of the emergency medical readiness planners will not be another cavatating blow to the military. Attachment F in this paper shows the status of this process. At this time the research is done, the data has been briefed to the USAF Medical Service medical leadership, and some good is already beginning to be seen. Without dedicated, tenured/experienced planners, all facets of medical readiness will falter and programs will just evaporate away, unplanned, unprogrammed, unfunded, and yes unfielded.

RECOMMENDATIONS

The following recommendations are those provided to the Surgeon General of the Air Force and the Medical Planners around the world.

1. *Assign A Full-Time Planning Position To JTF-SWA.* This is an essential requirement to meet

the current operational requirements in the theater. There are currently as many Air Force personnel serving in the Middle East on temporary rotations as there are on one year tours in Korea. Because of the tenuous situation, a medical planner is necessary to plan for and execute the full range of emergency medical operations until reinforced should combat commence.

2. *Institute The Temporary Duty Rotation of Qualified Planners Into SWA.* To back up the former described planner position, rotations of qualified planners should commence on 120 day rotations. This will permit split ops planning in both Kuwait and other locations, as well as the Headquarters in Riyadh.

3. *Introduce An Aeromedical Evacuation Operations Fellowship Training Program at Headquarters Air Mobility Command To Grow AE Planners.* To resolve the issue in the shortage of AE qualified planners to support the Unified Commands and other theater planning staffs, AE planners need to be grown to take on these missions.

4. *Have Certification In Emergency Management Be Recognized By the AFMS For Board Certification.* To inspire a professional development of medical planners affiliation and certification are necessary. As a result it is recommended that the Certification in Emergency Management, provided by the National Coordinating Council on Emergency Management be installed as a board certification mechanism for medical planners.

5. *Assign Experienced Planners To The U.S. Southern Command, U.S. Forces Korea, U.S. Pacific Command, and U.S. Central Command Surgeon Staffs.* Without these critical corners of the world covered with experienced planners, our theater focus will diminish and we will continue to fall behind in preparedness.

6. *Accomplish Theater Position Fills With Experienced Planners As The Highest Assignment Priority Of The Surgeon General's Office.* It is within the theater of operations that the Air

Force will execute within, and where casualties will be generated. This is where the priority needs to be emphasized for assignment of experienced planners.

7. Insure That All Unified And Sub-Area/Unified Command Surgeon Offices Have Experienced Theater Planners Resident On the Staff. This will be satisfied if the two above are met.

8. Assign No Less Than One Aeromedical Evacuations Operations Experienced Officer to the U.S. TRANSCOM Surgeons Office. In Fact, No One Should Be Assigned To This Office Unless They Have Such Experience. If this command is going to continue to lead the Armed Forces in the planning for AE, it should have individuals assigned who understands the processes and planning constraints, and factors for success.

9. Insure That All Unified and Sub-Area/Unified Command Surgeon Offices Have Experienced Aeromedical Evacuation Planners On The Staff. Since AE is a core competency of the Air Force it only seems right that the Air Force representative planners have AE experience. The other services will not provide this expertise. The Air Force has to accomplish this mission.

10. Insure That All Joint and Air Component Surgeon Staffs Have One Planner Assigned Who Has Theater Aeromedical Evacuation Experience. The rationale for this is spelled out in a similar fashion as in the previous paragraph.

11. Institute The Use of the "R" Prefix For Planner Positions As A Universal Criteria For Managing Planners and Planner Positions Throughout the Air Force Medical Service. The R prefix is available to codify individuals on the specialty code as professional planners. It is used by other career field planning functions. The AFMS needs to use this to maintain visibility over its force of planners for better utilization and reassignment.

12. Insure that Aeromedical Evacuation Squadron Directors of Operation Have Plan & Operations Experience (Especially those assigned to Theater Aeromedical Evacuation System

Squadrons). Squadron Directors of Operations are responsible for the operational employment of the squadron during contingencies/emergencies and require the necessary knowledge to understand the planning and employment processes and strategies.

13. *Insure That All Air Force Battle Labs Have Experienced Plans And Operations Personnel Assigned.* It is the mission of these agencies to test new systems employed during contingencies and other emergencies/operations.

14. *Assign An Experienced Plans & Operations Officer To The Air Force Doctrine Center at Maxwell AFB, Montgomery, Alabama.* It is the mission of the AFMS to support the deployed Air Forces of this nation and support its casualty care management. The doctrine required to support this mission needs to be written by an individual who has contingency plans experience.

15. *Assign Strong, Independent, and Proven/Planners to NAF and AFFOR Headquarters Positions.* These positions require theater experienced planners who can work independently from other staff and direct supervision since normally only one medical planner is assigned to these headquarters. As a result, this individual needs to come prepared to accomplish a full range of planning responsibilities.

16. *Reinstate A Mechanism For Monitoring Planner Staffing and Development.* This will be necessary to insure that we can continue to move planners into positions that assist in their development, while simultaneously meeting the critical planning mission needs of the Air Force.

17. *Define Plans Positions and Certification Process For Filling Planner Positions* (See Appendix E). This certification process, coupled with the recommendation in Number 16, will assist in the development and reassignment of planners.

18. *Promote The Practice of Planner Reassignment Based On The Best Interests Of The Air Force As a Corporate Institution, and Not Based Upon A Need To Move “Time/Clock “*

Mentality. All too often medical planners are randomly moved without regard as to how it affects the organization or work that the individual is supporting. The practice of moving individual, just because they have three years at a base, is ludicrous and needs to be stopped for the good of the Service.

19. *The Surgeon's Office Needs to Institute Marketing Of The Planning Field, Versus Ignoring the Reverse Marketing and Suspensions That Such Professional Path is Career Damaging.*

Meaning That Promotion Boards Should Be Highlighted. There has been for years an insidious undercurrent practiced by senior officer non medical planning types to harass individuals from becoming or remaining as planners. This "reverse marketing" dilemma has been one of the major reasons why there has been a significant exodus from the field, and hesitation entering it.

20. *Increase The Number of Readiness Planner Fellowship Positions and Plans Accessions.*

Historically this has survived as one of the best practices for bringing on and developing planners. It needs to be expanded for a few years, increasing the number of fellowships until the number of planners has stabilized.

21. *Medical Planners Should Be Given The Highest Priority For Senior Joint Service Schools.*

Senior Service Schools are designed with the medical planner in mind. Therefore, they need to be made more available as an incentive to this group.

22. *Consideration Should be Given To Establishing a Separate Air Force Specialty Code and Professional Career Field For Emergency Medical Service Planners.* Should the other above considerations falter, there would appear to be a need to consider making planners a separate career field within the AFMS. This would allow for more effective management, training, development, and reassignment of planners.

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